pitals. But it all seems logical. It is almost certain that the legitimate demands of interns and residents will somehow have to be met, not only in California but across the nation. The necessary funding will be substantial and will have to come from somewhere. If charity medicine is really to be a thing of the past, professional groups, which would include licensed interns and residents, should be permitted and encouraged to collect reasonable fees for services rendered in a teaching situation just as is done in practice. Let us hope that it will do so promptly.

It is suggested that the American Medical Association is the appropriate body to assume the leadership needed to unravel this complex problem.

What and Where And When to Learn

AN EXPANSION OF the listing of Continuing Medical Education Activities begins in this issue of CALIFORNIA MEDICINE. The listing is designed to provide physicians with a current catalogue of all continuing medical education opportunities throughout California and in Hawaii, projected three to four months in advance. This section will continue to bring together in one place the announcements of meetings and courses, major grand rounds, radio and television presentations, Audio-Digest and all other available educational activities, listed by specialty and giving the date, the sponsor, the location, the address for further information, and the fee. In addition specific program information will now be included to assist physicians in preliminary consideration of what to learn and where and when to do so.

By centralizing information regarding all of California's continuing medical education opportunities the Committee on Continuing Medical Education of the California Medical Association is now coming to a position from which to achieve coordination by offering a clearing house service for program sponsors. Sponsors are invited to consult the system regularly to avoid conflicts in planning programs and to aid in revealing gaps and reducing duplication. It is hoped that resulting coordination will ultimately lead to more efficient use of the resources of faculty and funds as well as of physicians' time.

Therapeutic Abortion And Mental Health

UNWANTED PREGNANCY causes one of the most severe psychological stresses in a woman's life. It seems logical, therefore, that under the new abortion law, the great majority of therapeutic abortions (86 percent) have been done to preserve the mental health of the mother. With the technical advances of modern medicine, there are relatively few physical conditions that necessitate an interruption of pregnancy. Mental illness is the most widespread and depleting public health problem in our society. Since the appearance of its various forms almost invariably follows a precipitating stress, the appearance, recurrence or exacerbation of mental disease at the time of pregnancy is most understandable.

There are many factors in the stress of unwanted pregnancy, some internal and characteristic of the individual and her particular circumstances, and some external, emerging from our society and its attitudes. This environment is hostile in varying degrees to the woman who does not want to be pregnant, and particularly to the one who, whether married or unmarried, wishes to get rid of that pregnancy. If unmarried, she is further condemned for "immoral" behavior, and continuation of the pregnancy is often seen as a justifiable punishment. The criticism, disappointment, rejection and ostracism, whether real or fantasied, originating from those persons most important to the woman are stresses with which she must cope.

And what of the internal factors? There is an obvious struggle between the protective feeling, so universal in women, toward the concept of giving birth to a new life and one that will live on after her, and the panic of helplessness and hopelessness at the reality of her predicament. Pregnancy can have many different meanings to a woman and always necessitates adjustments, emotional as well as physical, which the emotionally handicapped or potentially handicapped woman may not be able to make, at least without depletion of her mental health.

What kinds of conscious, or unconscious, motivations lead to a woman's becoming pregnant and then desperately not wanting to bear the child? To the young the event may be due to ignorance, or it may be a demonstration of adulthood, a gift to a parent or a passport from a stifling home situation. An unwanted pregnancy may be a confirmation of a woman's femininity, a proof of "having been loved" or a trap for a desired man. It may be due to contraceptive failure, whether human or mechanical. The defenses which individuals use to protect themselves make the true motivations of this condition often unclear.

Hence the burden of assessing the probable effects of continuance of the pregnancy falls to the physician, who in turn must help the woman weigh her own often ambivalent feelings. One of the controversial aspects of the situation is the undeniable effects of sociological factors on an individual's mental health. The stress and consequences of an unwanted pregnancy as they affect mental health must be determined for an individual patient, taking into consideration her total life situation. Factors such as marital status, family support, economic conditions, subcultural attitudes toward the pregnancy, and personality structure all contribute toward her ability to maintain and complete her pregnancy without damage to her mental functioning.

The new law requires physicians to make judgments that are difficult to make, impossible to prove and of crucial importance to the patient's welfare and the welfare of those dependent on her and intimately involved with her. The burden of responsibility on the psychiatrist and the gynecological surgeon are great, particularly with the time pressure of advancing pregnancy.

Diagnoses of the mental disorders have fallen into almost every category, even that of homosexuality, with a preponderance, in most series, of psychoneurotic depressive reaction, emotionally unstable personality trait disturbance, schizoid personality pattern disturbance, and schizophrenic reaction of the chronic undifferentiated type. Psychometric tests have yielded helpful data in many cases. In a series in our University of California Clinic, the scales most frequently elevated on the Minnesota Multiphasic Personality Inventory (MMPI) were those of psychopathological deviancy, depression, schizophrenia and hypomania. Goldberg's Psychoticism Index on this test showed 52 percent in the psychotic range and 29 percent in the neurotic range, with 18 percent indeterminate.

A follow-up study of a group of these patients is now being concluded, which includes a second MMPI three to four months after the initial one, and a comprehensive interview and questionnaire with the social worker. The data have yet to be analyzed and tabulated, but the subjective impressions recorded promise to be most interesting. One woman, the mother of six living children, reported that for the first time she felt like a person, and not like a factory.

A psychiatrist in San Francisco[11] has studied a group of 40 patients, whom he had judged to be in need of abortion on psychiatric grounds. Twenty-five percent of these patients had had previous psychiatric care, 25 percent had made suicide attempts or gestures before the pregnancy occurred, and 65 percent had made threats of suicide since the pregnancy had been recognized. In an 80 percent returned questionnaire at three to four months, there were no serious psychiatric sequelae. Guilt feelings at two weeks were reported to have been absent by 18 of the 40, mild in seven, moderate in three and severe in four. At three to four weeks, the report shifted to absent in 29, mild in two, moderate in none and severe in one. The attitudes toward a repeat of the same course of action were 81 percent affirmative without reservation; 13 percent unsure; 3 percent negative; and 3 percent said they would repeat the procedure only outside the law—illegally—the latter a comment on the toll of our often traumatic procedure of investigation and evaluation beforehand.

On a depression rating scale, the group mean score decreased by over 50 percent (a highly significant drop) between two weeks and three to four months postoperatively.

One important facet of this problem is the effect of therapeutic abortion itself on the mental health of the woman. At a public meeting when I commented on this consideration in some patients, Pat Maginnis, the abortion crusader, said, "Yes, there is a psychological reaction—relief!" Actually, carefully done studies indicate that serious psychiatric sequelae are minimal—Ekblad (1955),[5] Simon (1966)[15] and Peck (1966).[13] Transient depressive reactions were common but selflimited, and, interestingly, one report indicated they were less common after abortions performed on psychiatric grounds than those due to other considerations.

Jerome Kummer in 1963[8] reported that among

32 psychiatrists in the Los Angeles area, 75 percent had never encountered any moderate to severe sequelae of abortion, and the remaining 25 percent only rarely had met with serious post-abortion mental disturbance. He quoted a Copenhagen psychiatrist who stated that in 30,000 cases of induced abortion in 15 years, there were no serious sequelae. One problem in evaluating the literature is that European statistics usually apply to therapeutic abortion, whereas American studies include all types, spontaneous, induced and, in some, even illegal. When psychiatric sequelae are reported, resulting from an abortion, one must consider what sequelae might have emerged with pregnancy, delivery and either giving up or rearing the child. Truly, a pregnancy going to term is a life-long commitment for a woman. Giving up the child for adoption does not end the concern, and often it brings about self-recrimination. A therapy group of unwed mothers with whom I met for two years voiced these longings poignantly, and some celebrated the birthday of their lost infants, wondering what sort of life they were experiencing.

It seems, therefore, that abortion may prove to be the best course of the alternatives available to a patient. But it is almost never a complete solution to the woman's problem. The factors that were involved in the unwanted pregnancy must be understood and resolved if possible. Some degree of guilt and sense of loss almost invariably exists in the woman. The underlying psychological problems that have either been involved in her allowing herself to become pregnant, or at least have caused her to be unable to adjust to it, must be treated.

This poses a problem for all of us in the medical field. Follow-up psychotherapy in some form is often not available, or if so is unacceptable, due to economic problems, geographic difficulties, family factors and other reasons. With the decrease in anxiety occasioned by symptomatic relief of the pregnancy, motivation to continue therapy is often lacking. I believe that by working with the women in group therapy on a crisis basis for the two weeks before, during and following the abortion, we might guide more of them to continuing therapy. With such a program we might avoid the tragedy of subsequent unwanted pregnancies.

We must also help women avoid this defeating situation. Physicians caring for families and children can help parents to develop better relationships with their children, thus increasing the child's sense of identity and worth, and guiding him to more stable mental and sexual maturity. The parents' task in this fast-moving, fast-changing world is awesome, and professional help is often crucial.

Comprehensive family life and sex education in the schools can prepare youth for more responsible sexual behavior and responsible parenthood. Family planning information and availability need to be greatly extended, so that pregnancy can be a choice made by individual parents, according to their own beliefs.

Perhaps we as a society have been asking the wrong questions. Could we ask instead, "Does an unequivocally unwanted pregnancy *help* any woman? Does birth as an unwanted child give a *fair* opportunity to any child?" Prevention of unwanted pregnancy is far more humane than treatment of it. This more positive approach could lead to a more enlightened day, in which we would deal with the problem of prevention of unwanted pregnancy, rather than its interruption.

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